First Regular Session 115th General Assembly (2007)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2006 Regular Session of the General Assembly.

SENATE ENROLLED ACT No. 503

AN ACT to amend the Indiana Code concerning health care.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 12-15-15-1.1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1.1. (a) This section applies to a hospital that is:

(1) licensed under IC 16-21; and

(2) established and operated under IC 16-22-2, IC 16-22-8, or IC 16-23.

(b) For a state fiscal year ending after June 30, 2003, in addition to reimbursement received under section 1 of this chapter, a hospital is entitled to reimbursement in an amount calculated as follows:

STEP ONE: The office shall identify the aggregate inpatient hospital services, reimbursable under this article and under the state Medicaid plan, that were provided during the state fiscal year by hospitals established and operated under IC 16-22-2, IC 16-22-8, or IC 16-23.

STEP TWO: For the aggregate inpatient hospital services identified under STEP ONE, the office shall calculate the aggregate payments made under this article and under the state Medicaid plan to hospitals established and operated under IC 16-22-2, IC 16-22-8, or IC 16-23, excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP THREE: The office shall calculate a reasonable estimate of the amount that would have been paid in the aggregate by the office for the inpatient hospital services described in STEP ONE under Medicare payment principles.

STEP FOUR: Subtract the amount calculated under STEP TWO from the amount calculated under STEP THREE.

STEP FIVE: Subject to subsection (g), from the amount calculated under STEP FOUR, allocate to a hospital established and operated under IC 16-22-8 an amount ~~equal to~~ **not to exceed** one hundred percent (100%) of the difference between:

(A) the total cost for the hospital's provision of inpatient services covered under this article for the hospital's fiscal year ending during the state fiscal year; and

(B) the total payment to the hospital for its provision of inpatient services covered under this article for the hospital's fiscal year ending during the state fiscal year, excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP SIX: Subtract the amount calculated under STEP FIVE from the amount calculated under STEP FOUR.

STEP SEVEN: Distribute an amount equal to the amount calculated under STEP SIX to the eligible hospitals established and operated under IC 16-22-2 or IC 16-23 described in subsection (c) in ~~proportion to~~ **an amount not to exceed** each hospital's Medicaid shortfall as defined in subsection (f).

(c) Subject to subsection (e), reimbursement for a state fiscal year under this section consists of payments made after the close of each state fiscal year. ~~Payment for a state fiscal year ending after June 30, 2003, shall be made before December 31 following the state fiscal year's end.~~ A hospital is not eligible for a payment described in this subsection unless an intergovernmental transfer **or certification of expenditures** is made under subsection (d).

(d) Subject to subsection (e):

~~a hospital may make an intergovernmental transfer under this subsection, or~~ **(1)** an intergovernmental transfer may be made **by or** on behalf of the hospital; **or**

(2) a certification of expenditures as eligible for federal financial participation may be made;

after the close of each state fiscal year. An intergovernmental transfer under this subsection must be made to the Medicaid indigent care trust fund in an amount equal to a percentage, as determined by the office, of the amount to be distributed to the hospital under ~~STEP SEVEN of subsection (b). In determining the percentage, the office shall apply the~~

~~same percentage of not more than eighty-five percent (85%) to all hospitals eligible for reimbursement under STEP SEVEN of subsection (b).~~ **this section.** The office shall use the intergovernmental transfer to fund payments made under this section. ~~and as otherwise provided under IC 12-15-20-2(8).~~

(e) A hospital ~~making~~ **that makes a certification of expenditures or makes or has** an intergovernmental transfer **made on the hospital's behalf** under ~~subsection (d)~~ **this section** may appeal under IC 4-21.5 the amount determined by the office to be paid the hospital under ~~STEP SEVEN of~~ subsection (b). The periods described in subsections (c) and (d) for the hospital **or another entity** to make an intergovernmental transfer **or certification of expenditures** are tolled pending the administrative appeal and any judicial review initiated by the hospital under IC 4-21.5. The distribution to other hospitals under ~~STEP SEVEN of~~ subsection (b) may not be delayed due to an administrative appeal or judicial review instituted by a hospital under this subsection. If necessary, the office may make a partial distribution to the other eligible hospitals under ~~STEP SEVEN of~~ subsection (b) pending the completion of a hospital's administrative appeal or judicial review, at which time the remaining portion of the payments due to the eligible hospitals shall be made. A partial distribution may be based upon estimates and trends calculated by the office.

(f) For purposes of this section:

(1) the Medicaid shortfall of a hospital established and operated under IC 16-22-2 or IC 16-23 is calculated as follows:

STEP ONE: The office shall identify the inpatient hospital services, reimbursable under this article and under the state Medicaid plan, that were provided during the state fiscal year by the hospital.

STEP TWO: For the inpatient hospital services identified under STEP ONE, the office shall calculate the payments made under this article and under the state Medicaid plan to the hospital, excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP THREE: The office shall calculate a reasonable estimate of the amount that would have been paid by the office for the inpatient hospital services described in STEP ONE under Medicare payment principles; and

(2) a hospital's Medicaid shortfall is equal to the amount by which the amount calculated in STEP THREE of subdivision (1) is greater than the amount calculated in STEP TWO of subdivision (1).

(g) The actual distribution of the amount calculated under STEP FIVE of subsection (b) to a hospital established and operated under IC 16-22-8 shall be made under the terms and conditions provided for the hospital in the state plan for medical assistance. Payment to a hospital under STEP FIVE of subsection (b) is not a condition precedent to the tender of payments to hospitals under STEP SEVEN of subsection (b).

SECTION 2. IC 12-15-15-1.3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1.3. (a) This section applies to a hospital that is:

(1) licensed under IC 16-21; and

(2) established and operated under IC 16-22-2, IC 16-22-8, or IC 16-23.

(b) For a state fiscal year ending after June 30, 2003, in addition to reimbursement received under section 1 of this chapter, a hospital is entitled to reimbursement in an amount calculated as follows:

STEP ONE: The office shall identify the aggregate outpatient hospital services, reimbursable under this article and under the state Medicaid plan, that were provided during the state fiscal year by hospitals established and operated under IC 16-22-2, IC 16-22-8, or IC 16-23.

STEP TWO: For the aggregate outpatient hospital services identified under STEP ONE, the office shall calculate the aggregate payments made under this article and under the state Medicaid plan to hospitals established and operated under IC 16-22-2, IC 16-22-8, or IC 16-23, excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP THREE: The office shall calculate a reasonable estimate of the amount that would have been paid in the aggregate by the office under Medicare payment principles for the outpatient hospital services described in STEP ONE.

STEP FOUR: Subtract the amount calculated under STEP TWO from the amount calculated under STEP THREE.

STEP FIVE: Subject to subsection (g), from the amount calculated under STEP FOUR, allocate to a hospital established and operated under IC 16-22-8 an amount ~~equal to~~ **not to exceed** one hundred percent (100%) of the difference between:

(A) the total cost for the hospital's provision of outpatient services covered under this article for the hospital's fiscal year ending during the state fiscal year; and

(B) the total payment to the hospital for its provision of outpatient services covered under this article for the hospital's

fiscal year ending during the state fiscal year, excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP SIX: Subtract the amount calculated under STEP FIVE from the amount calculated under STEP FOUR.

STEP SEVEN: Distribute an amount equal to the amount calculated under STEP SIX to the eligible hospitals established and operated under IC 16-22-2 or IC 16-23 described in subsection (c) in ~~proportion to~~ **an amount not to exceed** each hospital's Medicaid shortfall as defined in subsection (f).

(c) ~~Subject to subsection (e), the reimbursement for a state fiscal year under this section consists of payments made before December 31 following the end of the state fiscal year.~~ A hospital is not eligible for a payment described in this ~~subsection~~ **section** unless:

(1) an intergovernmental transfer is made ~~under subsection (d).~~ **by the hospital or on behalf of the hospital; or**

(2) the hospital or another entity certifies the hospital's expenditures as eligible for federal financial participation.

(d) Subject to subsection (e):

~~a hospital may make an intergovernmental transfer under this subsection, or~~ **(1)** an intergovernmental transfer may be made **by or** on behalf of the hospital; **or**

(2) a certification of expenditures as eligible for federal financial participation may be made;

after the close of each state fiscal year. An intergovernmental transfer under this subsection must be made to the Medicaid indigent care trust fund in an amount equal to a percentage, as determined by the office, of the amount to be distributed to the hospital under ~~STEP SEVEN of~~ subsection (b). ~~In determining the percentage, the office shall apply the same percentage of not more than eighty-five percent (85%) to all hospitals eligible for reimbursement under STEP SEVEN of subsection (b).~~ The office shall use the intergovernmental transfer to fund payments made under this section. ~~and as otherwise provided under IC 12-15-20-2(8).~~

(e) A hospital ~~making~~ **that makes a certification of expenditures or makes or has** an intergovernmental transfer **made on the hospital's behalf** under ~~subsection (d)~~ **this section** may appeal under IC 4-21.5 the amount determined by the office to be paid by the hospital under ~~STEP SEVEN of~~ subsection (b). The periods described in subsections (c) and (d) for the hospital **or other entity** to make an intergovernmental transfer **or certification of expenditures** are tolled pending the administrative appeal and any judicial review initiated by the hospital under IC 4-21.5. The distribution to other hospitals under

~~STEP~~ ~~SEVEN~~ ~~of~~ subsection (b) may not be delayed due to an administrative appeal or judicial review instituted by a hospital under this subsection. If necessary, the office may make a partial distribution to the other eligible hospitals under ~~STEP~~ ~~SEVEN~~ ~~of~~ subsection (b) pending the completion of a hospital's administrative appeal or judicial review, at which time the remaining portion of the payments due to the eligible hospitals must be made. A partial distribution may be calculated by the office based upon estimates and trends.

(f) For purposes of this section:

(1) the Medicaid shortfall of a hospital established and operated under IC 16-22-2 or IC 16-23 is calculated as follows:

STEP ONE: The office shall identify the outpatient hospital services, reimbursable under this article and under the state Medicaid plan, that were provided during the state fiscal year by the hospital.

STEP TWO: For the outpatient hospital services identified under STEP ONE, the office shall calculate the payments made under this article and under the state Medicaid plan to the hospital, excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP THREE: The office shall calculate a reasonable estimate of the amount that would have been paid by the office for the outpatient hospital services described in STEP ONE under Medicare payment principles; and

(2) a hospital's Medicaid shortfall is equal to the amount by which the amount calculated in STEP THREE of subdivision (1) is greater than the amount calculated in STEP TWO of subdivision (1).

(g) The actual distribution of the amount calculated under STEP FIVE of subsection (b) to a hospital established and operated under IC 16-22-8 shall be made under the terms and conditions provided for the hospital in the state plan for medical assistance. Payment to a hospital under STEP FIVE of subsection (b) is not a condition precedent to the tender of payments to hospitals under STEP SEVEN of subsection (b).

SECTION 3. IC 12-15-15-1.5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1.5. (a) This section applies to a hospital that:

(1) is licensed under IC 16-21;

(2) is not a unit of state or local government; and

(3) is not owned or operated by a unit of state or local government.

(b) For a state fiscal year ending after June 30, 2003, **and before July 1, 2007,** in addition to reimbursement received under section 1 of this chapter, a hospital eligible under this section is entitled to reimbursement in an amount calculated as follows:

STEP ONE: The office shall identify the total inpatient hospital services and the total outpatient hospital services, reimbursable under this article and under the state Medicaid plan, that were provided during the state fiscal year by the hospitals described in subsection (a).

STEP TWO: For the total inpatient hospital services and the total outpatient hospital services identified under STEP ONE, the office shall calculate the aggregate payments made under this article and under the state Medicaid plan to hospitals described in subsection (a), excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP THREE: The office shall calculate a reasonable estimate of the amount that would have been paid in the aggregate by the office for the inpatient hospital services and the outpatient hospital services identified in STEP ONE under Medicare payment principles.

STEP FOUR: Subtract the amount calculated under STEP TWO from the amount calculated under STEP THREE.

STEP FIVE: Distribute an amount equal to the amount calculated under STEP FOUR to the eligible hospitals described in subsection (a) as follows:

(A) Subject to the availability of funds under IC 12-15-20-2(8)(D) to serve as the non-federal share of such payment, the first ten million dollars ($10,000,000) of the amount calculated under STEP FOUR for a state fiscal year shall be paid to a hospital described in subsection (a) that has more than ~~seventy~~ **sixty** thousand ~~(70,000)~~ **(60,000)** Medicaid inpatient days.

(B) Following the payment to the hospital under clause (A) and subject to the availability of funds under IC 12-15-20-2(8)(D) to serve as the non-federal share of such payments, the remaining amount calculated under STEP FOUR for a state fiscal year shall be paid to all hospitals described in subsection (a). The payments shall be made on a pro rata basis based on the hospitals' Medicaid inpatient days or other payment methodology approved by the Centers for Medicare and Medicaid Services. **For purposes of this clause, a hospital's Medicaid inpatient days are the**

hospital's in-state and paid Medicaid fee for service and managed care days for the state fiscal year for which services are identified under STEP ONE, as determined by the office.

(C) Subject to IC 12-15-20.7, in the event the entirety of the amount calculated under STEP FOUR is not distributed following the payments made under clauses (A) and (B), the remaining amount may be paid to hospitals described in subsection (a) that are eligible under this clause. A hospital is eligible for a payment under this clause only if the non-federal share of the hospital's payment is provided by or on behalf of the hospital. The remaining amount shall be paid to those eligible hospitals:

(i) on a pro rata basis in relation to all hospitals eligible under this clause based on the hospitals' Medicaid inpatient days; or

(ii) other payment methodology **determined by the office and** approved by the Centers for Medicare and Medicaid Services.

~~(D) For purposes of the clauses (A), (B) and (C), a hospital's Medicaid inpatient days are based on the Medicaid inpatient days allowed for the hospital by the office for purposes of the office's most recent determination of eligibility for the Medicaid disproportionate payment program under IC 12-15-16.~~

(c) ~~Reimbursement for a state fiscal year under this section consists of payments made after the close of each state fiscal year. Payment for a state fiscal year ending after June 30, 2003, shall be made before December 31 following the end of the state fiscal year.~~ **As used in this subsection, "Medicaid supplemental payments" means Medicaid payments for hospitals that are in addition to Medicaid fee-for-service payments, Medicaid risk-based managed care payments, and Medicaid disproportionate share payments, and that are included in the Medicaid state plan, including Medicaid safety-net payments, and payments made under sections 1.1, 1.3, 1.5, 9, and 9.5 of this chapter. For a state fiscal year ending after June 30, 2007, in addition to the reimbursement received under section 1 of this chapter, a hospital eligible under this section is entitled to reimbursement in an amount calculated as follows:**

STEP ONE: The office shall identify the total inpatient hospital services and the total outpatient hospital services reimbursable under this article and under the state Medicaid

plan that were provided during the state fiscal year for all hospitals described in subsection (a).

STEP TWO: For the total inpatient hospital services and the total outpatient hospital services identified in STEP ONE, the office shall calculate the total payments made under this article and under the state Medicaid plan to all hospitals described in subsection (a). A calculation under this STEP excludes a payment made under the following:

(A) IC 12-15-16.

(B) IC 12-15-17.

(C) IC 12-15-19.

STEP THREE: The office shall calculate, under Medicare payment principles, a reasonable estimate of the total amount that would have been paid by the office for the inpatient hospital services and the outpatient hospital services identified in STEP ONE.

STEP FOUR: Subtract the amount calculated under STEP TWO from the amount calculated under STEP THREE.

STEP FIVE: Distribute an amount equal to the amount calculated under STEP FOUR to the eligible hospitals described in subsection (a) as follows:

(A) As used in this clause, "Medicaid inpatient days" are the hospital's in-state paid Medicaid fee for service and risk-based managed care days for the state fiscal year for which services are identified under STEP ONE, as determined by the office. Subject to the availability of funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(c) and remaining in the Medicaid indigent care trust fund under IC 12-15-20-2(8)(G) to serve as the non-federal share of the payments, the amount calculated under STEP FOUR for a state fiscal year shall be paid to all hospitals described in subsection (a). The payments shall be made on a pro rata basis, based on the hospitals' Medicaid inpatient days or in accordance with another payment methodology determined by the office and approved by the Centers for Medicare and Medicaid Services.

(B) Subject to IC 12-15-20.7, if the entire amount calculated under STEP FOUR is not distributed following the payments made under clause (A), the remaining amount shall be paid as described in clauses (C) and (D) to a hospital that is described in subsection (a) and that is

described as eligible under this clause. A hospital is eligible for a payment under clause (C) only if the hospital:

(i) has less than sixty thousand (60,000) Medicaid inpatient days annually;

(ii) was eligible for Medicaid disproportionate share hospital payments in the state fiscal year ending June 30, 1998, or the hospital met the office's Medicaid disproportionate share payment criteria based upon state fiscal year 1998 data and received a Medicaid disproportionate share payment for the state fiscal year ending June 30, 2001; and

(iii) received a Medicaid disproportionate share payment under IC 12-15-19-2.1 for state fiscal years 2001, 2002, 2003, and 2004.

The payment amount under clause (C) for an eligible hospital is subject to the availability of the non-federal share of the hospital's payment being provided by the hospital or on behalf of the hospital.

(C) For state fiscal years ending after June 30, 2007, but before July 1, 2009, payments to eligible hospitals described in clause (B) shall be made as follows:

(i) The payment to an eligible hospital that merged two (2) hospitals under a single Medicaid provider number effective January 1, 2004, shall equal one hundred percent (100%) of the hospital's hospital-specific limit for the state fiscal year ending June 30, 2005, when the payment is combined with any Medicaid disproportionate share payment made under IC 12-15-19-2.1, Medicaid, and other Medicaid supplemental payments, paid or to be paid to the hospital for a state fiscal year.

(ii) The payment to an eligible hospital described in clause (B) other than a hospital described in item (i) shall equal one hundred percent (100%) of the hospital's hospital specific limit for the state fiscal year ending June 30, 2004, when the payment is combined with any Medicaid disproportionate share payment made under IC 12-15-19-2.1, Medicaid, and other Medicaid supplemental payments, paid or to be paid to the hospital for a state fiscal year.

(D) For state fiscal years beginning after June 30, 2009, payments to an eligible hospital described in clause (B)

shall be made in a manner determined by the office.

(E) Subject to IC 12-15-20.7, if the entire amount calculated under STEP FOUR is not distributed following the payments made under clause (A), and clauses (C) or (D), the remaining amount may be paid as described in clause (F) to a hospital described in subsection (a) that is described as eligible under this clause. A hospital is eligible for a payment for a state fiscal year under clause (F) if the hospital:

(i) is eligible to receive Medicaid disproportionate share payments for the state fiscal year for which the Medicaid disproportionate share payment is attributable under IC 12-15-19-2.1, for a state fiscal year ending after June 30, 2007; and

(ii) does not receive a payment under clauses (C) or (D) for the state fiscal year.

A payment to a hospital under this clause is subject to the availability of non-federal matching funds.

(F) Payments to eligible hospitals described in clause (E) shall be made:

(i) to best use federal matching funds available for hospitals that are eligible for Medicaid disproportionate share payments under IC 12-15-19-2.1; and

(ii) by using a methodology that allocates available funding under this clause, Medicaid supplemental payments, and payments under IC 12-15-19-2.1, in a manner in which all hospitals eligible under clause (E) receive payments in a manner that takes into account the situation of eligible hospitals that have historically qualified for Medicaid disproportionate share payments and ensures that payments for eligible hospitals are equitable.

(G) If the Centers for Medicare and Medicaid Services does not approve the payment methodologies in clauses (A) through (F), the office may implement alternative payment methodologies, that are eligible for federal financial participation, to implement a program consistent with the payments for hospitals described in clauses (A) through (F).

(d) A hospital described in subsection (a) may appeal under IC 4-21.5 the amount determined by the office to be paid to the hospital under STEP FIVE of ~~subsection~~ **subsections** (b) **or (c).** The

distribution to other hospitals under STEP FIVE of subsection (b) **or (c)** may not be delayed due to an administrative appeal or judicial review instituted by a hospital under this subsection. If necessary, the office may make a partial distribution to the other eligible hospitals under STEP FIVE of subsection (b) **or (c)** pending the completion of a hospital's administrative appeal or judicial review, at which time the remaining portion of the payments due to the eligible hospitals shall be made. A partial distribution may be based on estimates and trends calculated by the office.

SECTION 4. IC 12-15-15-9 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 9. (a) For purposes of this section and IC 12-16-7.5-4.5, a payable claim is attributed to a county if the payable claim is submitted to the division by a hospital licensed under IC 16-21-2 for payment under IC 12-16-7.5 for care provided by the hospital to an individual who qualifies for the hospital care for the indigent program under IC 12-16-3.5-1 or IC 12-16-3.5-2 and:

(1) who is a resident of the county;

(2) who is not a resident of the county and for whom the onset of the medical condition that necessitated the care occurred in the county; or

(3) whose residence cannot be determined by the division and for whom the onset of the medical condition that necessitated the care occurred in the county.

(b) For each state fiscal year ending after June 30, 2003, **and before July 1, 2007,** a hospital licensed under IC 16-21-2 that submits to the division during the state fiscal year a payable claim under IC 12-16-7.5 is entitled to a payment under ~~this section.~~ **subsection (c).**

(c) Except as provided in section 9.8 of this chapter and subject to section 9.6 of this chapter, for a state fiscal year, the office shall pay to a hospital referred to in subsection (b) an amount equal to the amount, based on information obtained from the division and the calculations and allocations made under IC 12-16-7.5-4.5, that the office determines for the hospital under STEP SIX of the following STEPS:

STEP ONE: Identify:

(A) each hospital that submitted to the division one (1) or more payable claims under IC 12-16-7.5 during the state fiscal year; and

(B) the county to which each payable claim is attributed.

STEP TWO: For each county identified in STEP ONE, identify:

(A) each hospital that submitted to the division one (1) or more payable claims under IC 12-16-7.5 attributed to the

county during the state fiscal year; and

(B) the total amount of all hospital payable claims submitted to the division under IC 12-16-7.5 attributed to the county during the state fiscal year.

STEP THREE: For each county identified in STEP ONE, identify the amount of county funds transferred to the Medicaid indigent care trust fund under ~~STEP FOUR of IC 12-16-7.5-4.5(b).~~ **IC 12-16-7.5-4.5.**

STEP FOUR: For each hospital identified in STEP ONE, with respect to each county identified in STEP ONE, calculate the hospital's percentage share of the county's funds transferred to the Medicaid indigent care trust fund under ~~STEP FOUR of IC 12-16-7.5-4.5(b).~~ **IC 12-16-7.5-4.5.** Each hospital's percentage share is based on the total amount of the hospital's payable claims submitted to the division under IC 12-16-7.5 attributed to the county during the state fiscal year, calculated as a percentage of the total amount of all hospital payable claims submitted to the division under IC 12-16-7.5 attributed to the county during the state fiscal year.

STEP FIVE: Subject to subsection (j), for each hospital identified in STEP ONE, with respect to each county identified in STEP ONE, multiply the hospital's percentage share calculated under STEP FOUR by the amount of the county's funds transferred to the Medicaid indigent care trust fund under ~~STEP FOUR of IC 12-16-7.5-4.5(b).~~ **IC 12-16-7.5-4.5.**

STEP SIX: Determine the sum of all amounts calculated under STEP FIVE for each hospital identified in STEP ONE with respect to each county identified in STEP ONE.

(d) For state fiscal years beginning after June 30, 2007, a hospital that received a payment determined under STEP SIX of subsection (c) for the state fiscal year ending June 30, 2007, shall be paid in an amount equal to the amount determined for the hospital under STEP SIX of subsection (c) for the state fiscal year ending June 30, 2007.

~~(d)~~ **(e)** A hospital's payment under subsection (c) **or (d)** is in the form of a Medicaid ~~add-on~~ **supplemental** payment. The amount of a hospital's ~~add-on~~ **Medicaid supplemental** payment is subject to the availability of funding for the non-federal share of the payment under subsection ~~(c).~~ **(f).** The office shall make the payments under subsection (c) **and (d)** before December 15 that next succeeds the end of the state fiscal year.

~~(c)~~ **(f)** The non-federal share of a payment to a hospital under

subsection (c) **or (d)** is funded from the funds transferred to the Medicaid indigent care trust fund under ~~STEP FOUR of IC 12-16-7.5-4.5(b) of each county to which a payable claim under IC 12-16-7.5 submitted to the division during the state fiscal year by the hospital is attributed.~~ **IC 12-16-7.5-4.5.**

~~(f)~~ **(g)** The amount of a county's transferred funds available to be used to fund the non-federal share of a payment to a hospital under subsection (c) is an amount that bears the same proportion to the total amount of funds of the county transferred to the Medicaid indigent care trust fund under ~~STEP FOUR of IC 12-16-7.5-4.5(b)~~ **IC 12-16-7.5-4.5** that the total amount of the hospital's payable claims under IC 12-16-7.5 attributed to the county submitted to the division during the state fiscal year bears to the total amount of all hospital payable claims under IC 12-16-7.5 attributed to the county submitted to the division during the state fiscal year.

~~(g)~~ **(h)** Any county's funds identified in subsection ~~(f)~~ **(g)** that remain after the non-federal share of a hospital's payment has been funded are available to serve as the non-federal share of a payment to a hospital under section 9.5 of this chapter.

~~(h)~~ **(i)** For purposes of this section, "payable claim" has the meaning set forth in IC 12-16-7.5-2.5(b)(1).

~~(i)~~ **(j)** For purposes of ~~this section.~~ **subsection (c):**

(1) the amount of a payable claim is an amount equal to the amount the hospital would have received under the state's fee-for-service Medicaid reimbursement principles for the hospital care for which the payable claim is submitted under IC 12-16-7.5 if the individual receiving the hospital care had been a Medicaid enrollee; and

(2) a payable hospital claim under IC 12-16-7.5 includes a payable claim under IC 12-16-7.5 for the hospital's care submitted by an individual or entity other than the hospital, to the extent permitted under the hospital care for the indigent program.

~~(j)~~ **(k)** The amount calculated under STEP FIVE of subsection (c) for a hospital with respect to a county may not exceed the total amount of the hospital's payable claims attributed to the county during the state fiscal year.

SECTION 5. IC 12-15-15-9.5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 9.5. (a) For purposes of this section and IC 12-16-7.5-4.5, a payable claim is attributed to a county if the payable claim is submitted to the division by a hospital licensed under IC 16-21-2 for payment under IC 12-16-7.5 for care provided by the hospital to an individual who qualifies for the hospital

care for the indigent program under IC 12-16-3.5-1 or IC 12-16-3.5-2 and;

(1) who is a resident of the county;

(2) who is not a resident of the county and for whom the onset of the medical condition that necessitated the care occurred in the county; or

(3) whose residence cannot be determined by the division and for whom the onset of the medical condition that necessitated the care occurred in the county.

(b) For each state fiscal year ending after June 30, 2003, **but before July 1, 2007,** a hospital licensed under IC 16-21-2:

(1) that submits to the division during the state fiscal year a payable claim under IC 12-16-7.5; and

(2) whose payment under section 9(c) of this chapter was less than the total amount of the hospital's payable claims under IC 12-16-7.5 submitted by the hospital to the division during the state fiscal year;

is entitled to a payment under ~~this section.~~ **subsection (c).**

(c) Except as provided in section 9.8 of this chapter and subject to section 9.6 of this chapter, for a state fiscal year, the office shall pay to a hospital referred to in subsection (b) an amount equal to the amount, based on information obtained from the division and the calculations and allocations made under IC 12-16-7.5-4.5, that the office determines for the hospital under STEP EIGHT of the following STEPS:

STEP ONE: Identify each county whose transfer of funds to the Medicaid indigent care trust fund under ~~STEP FOUR of IC 12-16-7.5-4.5(b)~~ **IC 12-16-7.5-4.5** for the state fiscal year was less than the total amount of all hospital payable claims attributed to the county and submitted to the division during the state fiscal year.

STEP TWO: For each county identified in STEP ONE, calculate the difference between the amount of funds of the county transferred to the Medicaid indigent care trust fund under ~~STEP FOUR of IC 12-16-7.5-4.5(b)~~ **IC 12-16-7.5-4.5** and the total amount of all hospital payable claims attributed to the county and submitted to the division during the state fiscal year.

STEP THREE: Calculate the sum of the amounts calculated for the counties under STEP TWO.

STEP FOUR: Identify each hospital whose payment under section 9(c) of this chapter was less than the total amount of the hospital's payable claims under IC 12-16-7.5 submitted by the hospital to the division during the state fiscal year.

STEP FIVE: Calculate for each hospital identified in STEP FOUR the difference between the hospital's payment under section 9(c) of this chapter and the total amount of the hospital's payable claims under IC 12-16-7.5 submitted by the hospital to the division during the state fiscal year.

STEP SIX: Calculate the sum of the amounts calculated for each of the hospitals under STEP FIVE.

STEP SEVEN: For each hospital identified in STEP FOUR, calculate the hospital's percentage share of the amount calculated under STEP SIX. Each hospital's percentage share is based on the amount calculated for the hospital under STEP FIVE calculated as a percentage of the sum calculated under STEP SIX.

STEP EIGHT: For each hospital identified in STEP FOUR, multiply the hospital's percentage share calculated under STEP SEVEN by the sum calculated under STEP THREE. The amount calculated under this STEP for a hospital may not exceed the amount by which the hospital's total payable claims under IC 12-16-7.5 submitted during the state fiscal year exceeded the amount of the hospital's payment under section 9(c) of this chapter.

(d) For state fiscal years beginning after June 30, 2007, a hospital that received a payment determined under STEP EIGHT of subsection (c) for the state fiscal year ending June 30, 2007, shall be paid an amount equal to the amount determined for the hospital under STEP EIGHT of subsection (c) for the state fiscal year ending June 30, 2007.

~~(d)~~ **(e)** A hospital's payment under subsection (c) **or (d)** is in the form of a Medicaid ~~add-on~~ **supplemental** payment. The amount of the hospital's add-on payment is subject to the availability of funding for the non-federal share of the payment under subsection ~~(c).~~ **(f).** The office shall make the payments under subsection (c) **or (d)** before December 15 that next succeeds the end of the state fiscal year.

~~(c)~~ **(f)** The non-federal share of a payment to a hospital under subsection (c) **or (d)** is derived from funds transferred to the Medicaid indigent care trust fund under ~~STEP FOUR of IC 12-16-7.5-4.5(b)~~ **IC 12-16-7.5-4.5** and not expended under section 9 of this chapter. ~~To the extent possible, the funds shall be derived on a proportional basis from the funds transferred by each county identified in subsection (c), STEP ONE:~~

~~(1) to which at least one (1) payable claim submitted by the hospital to the division during the state fiscal year is attributed; and~~

~~(2) whose funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) were not completely expended under section 9 of this chapter.~~

~~The amount available to be derived from the remaining funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) to serve as the non-federal share of the payment to a hospital under subsection (c) is an amount that bears the same proportion to the total amount of funds transferred by all the counties identified in subsection (c), STEP ONE, that the amount calculated for the hospital under subsection (c), STEP FIVE, bears to the amount calculated under subsection (c), STEP SIX.~~

~~(f)~~ **(g)** Except as provided in subsection ~~(g),~~ **(h),** the office may not make a payment under this section until the payments due under section 9 of this chapter for the state fiscal year have been made.

~~(g)~~ **(h)** If a hospital appeals a decision by the office regarding the hospital's payment under section 9 of this chapter, the office may make payments under this section before all payments due under section 9 of this chapter are made if:

(1) a delay in one (1) or more payments under section 9 of this chapter resulted from the appeal; and

(2) the office determines that making payments under this section while the appeal is pending will not unreasonably affect the interests of hospitals eligible for a payment under this section.

~~(h)~~ **(i)** Any funds transferred to the Medicaid indigent care trust fund under ~~STEP FOUR of IC 12-16-7.5-4.5(b)~~ **IC 12-16-7.5-4.5** remaining after payments are made under this section shall be used as provided in ~~IC 12-15-20-2(8)(D).~~ **IC 12-15-20-2(8).**

(i) For purposes of ~~this section:~~ **subsection (c):**

(1) "payable claim" has the meaning set forth in IC 12-16-7.5-2.5(b);

(2) the amount of a payable claim is an amount equal to the amount the hospital would have received under the state's fee-for-service Medicaid reimbursement principles for the hospital care for which the payable claim is submitted under IC 12-16-7.5 if the individual receiving the hospital care had been a Medicaid enrollee; and

(3) a payable hospital claim under IC 12-16-7.5 includes a payable claim under IC 12-16-7.5 for the hospital's care submitted by an individual or entity other than the hospital, to the extent permitted under the hospital care for the indigent program.

SECTION 6. IC 12-15-15-9.6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 9.6. **For state fiscal**

years beginning after June 30, 2007, the total amount of payments to hospitals under sections 9 and 9.5 of this chapter may not exceed the amount ~~transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b).~~ **paid to hospitals under sections 9 and 9.5 of this chapter for the state fiscal year ending June 30, 2007.**

SECTION 7. IC 12-15-15-10 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 10. (a) This section applies to a hospital that:

(1) is licensed under IC 16-21; and

(2) qualifies as a provider under **IC 12-15-16, IC 12-15-17, or IC 12-15-19 of** the Medicaid disproportionate share provider program.

(b) The office may, after consulting with affected providers, do one (1) or more of the following:

~~(1) Expand the payment program established under section 1.1(b) of this chapter to include all hospitals described in subsection (a).~~

~~(2)~~ **(1)** Establish a nominal charge hospital payment program.

~~(3)~~ **(2)** Establish any other permissible payment program.

(c) A program expanded or established under this section is subject to the availability of:

(1) intergovernmental transfers; ~~or~~

(2) funds certified as being eligible for federal financial participation; **or**

(3) other permissible sources of non-federal share dollars.

(d) The office may not implement a program under this section until the federal Centers for Medicare and Medicaid Services approves the provisions regarding the program in the amended state plan for medical assistance.

(e) The office may determine not to continue to implement a program established under this section if federal financial participation is not available.

SECTION 8. IC 12-15-19-2.1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 2.1. (a) For each state fiscal year ending on or after June 30, 2000, the office shall develop a disproportionate share payment methodology that ensures that each hospital qualifying for disproportionate share payments under IC 12-15-16-1(a) timely receives total disproportionate share payments that do not exceed the hospital's hospital specific limit provided under 42 U.S.C. 1396r-4(g). The payment methodology as developed by the office must:

(1) maximize disproportionate share hospital payments to

qualifying hospitals to the extent practicable;

(2) take into account the situation of those qualifying hospitals that have historically qualified for Medicaid disproportionate share payments; and

(3) ensure that payments ~~net of intergovernmental transfers made by or on behalf of~~ **for** qualifying hospitals are equitable.

(b) Total disproportionate share payments to a hospital under this chapter shall not exceed the hospital specific limit provided under 42 U.S.C. 1396r-4(g). The hospital specific limit for a state fiscal year shall be determined by the office taking into account data provided by each hospital that is considered reliable by the office based on a system of periodic audits, the use of trending factors, and an appropriate base year determined by the office. The office may require independent certification of data provided by a hospital to determine the hospital's hospital specific limit.

(c) The office shall include a provision in each amendment to the state plan regarding Medicaid disproportionate share payments that the office submits to the federal Centers for Medicare and Medicaid Services that, as provided in 42 CFR 447.297(d)(3), allows the state to make additional disproportionate share expenditures after the end of each federal fiscal year that relate back to a prior federal fiscal year. However, the total disproportionate share payments to:

(1) each individual hospital; and

(2) all qualifying hospitals in the aggregate;

may not exceed the limits provided by federal law and regulation.

~~(d) The office shall, in each state fiscal year, provide sufficient funds for acute care hospitals licensed under IC 16-21 that qualify for disproportionate share payments under IC 12-15-16-1(a). Funds provided under this subsection:~~

~~(1) do not include funds transferred by other governmental units to the Medicaid indigent care trust fund; and~~

~~(2) must be in an amount equal to the amount that results from the following calculation:~~

~~STEP ONE: Multiply twenty-six million dollars ($26,000,000) by the federal medical assistance percentage.~~

~~STEP TWO: Subtract the amount determined under STEP ONE from twenty-six million dollars ($26,000,000).~~

SECTION 9. IC 12-15-19-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 6. (a) The office is not required to make disproportionate share payments under this chapter from the Medicaid indigent care trust fund established by IC 12-15-20-1 until the fund has received sufficient deposits, **including**

intergovernmental transfers of funds and certifications of expenditures, to permit the office to make the state's share of the required disproportionate share payments.

(b) **For state fiscal years beginning after June 30, 2006,** if:

(1) sufficient deposits have not been received; **or**

(2) the statewide Medicaid disproportionate share allocation is insufficient to provide federal financial participation for the entirety of all eligible disproportionate share hospitals' hospital-specific limits;

the office shall reduce disproportionate share payments **made under IC 12-15-19-2.1 and Medicaid safety-net payments made in accordance with the Medicaid state plan** to ~~all~~ eligible institutions ~~by the same percentage.~~ **using an equitable methodology consistent with subsection (c).**

(c) For state fiscal years beginning after June 30, 2006, payments reduced under this section shall, in accordance with the Medicaid state plan, be made:

(1) to best utilize federal matching funds available for hospitals eligible for Medicaid disproportionate share payments under IC 12-15-19-2.1; and

(2) by utilizing a methodology that allocates available funding under this subdivision, and Medicaid supplemental payments as defined in IC 12-15-15-1.5, in a manner that all hospitals eligible for Medicaid disproportionate share payments under IC 12-15-19-2.1 receive payments using a methodology that:

(A) takes into account the situation of the eligible hospitals that have historically qualified for Medicaid disproportionate share payments; and

(B) ensures that payments for eligible hospitals are equitable.

(d) The percentage reduction shall be sufficient to ensure that payments do not exceed the **statewide Medicaid disproportionate share allocation or the** amounts that can be financed with:

(1) ~~the state share that is in~~ the **amount transferred from the hospital care for the indigent trust** fund;

(2) other intergovernmental transfers;

(3) certifications of public expenditures; or

(4) any other permissible sources of non-federal match.

SECTION 10. IC 12-15-20-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 2. The Medicaid indigent care trust fund is established to pay the non-federal share of the following:

(1) Enhanced disproportionate share payments to providers under IC 12-15-19-1.

(2) Subject to subdivision (8), disproportionate share payments to providers under IC 12-15-19-2.1.

(3) Medicaid payments for pregnant women described in IC 12-15-2-13 and infants and children described in IC 12-15-2-14.

(4) Municipal disproportionate share payments to providers under IC 12-15-19-8.

(5) Payments to hospitals under IC 12-15-15-9.

(6) Payments to hospitals under IC 12-15-15-9.5.

(7) Payments, funding, and transfers as otherwise provided in clauses (8)(D), ~~and~~ (8)(F), **and (8)(G).**

(8) Of the intergovernmental transfers deposited into the Medicaid indigent care trust fund, the following apply:

(A) The entirety of the intergovernmental transfers deposited into the Medicaid indigent care trust fund for state fiscal years ending on or before June 30, 2000, shall be used to fund the state's share of the disproportionate share payments to providers under IC 12-15-19-2.1.

(B) Of the intergovernmental transfers deposited into the Medicaid indigent care trust fund for the state fiscal year ending June 30, 2001, an amount equal to one hundred percent (100%) of the total intergovernmental transfers deposited into the Medicaid indigent care trust fund for the state fiscal year beginning July 1, 1998, and ending June 30, 1999, shall be used to fund the state's share of disproportionate share payments to providers under IC 12-15-19-2.1. The remainder of the intergovernmental transfers, if any, for the state fiscal year shall be used to fund the state's share of additional Medicaid payments to hospitals licensed under IC 16-21 pursuant to a methodology adopted by the office.

(C) Of the intergovernmental transfers deposited into the Medicaid indigent care trust fund, for state fiscal years beginning July 1, 2001, and July 1, 2002, an amount equal to:

(i) one hundred percent (100%) of the total intergovernmental transfers deposited into the Medicaid indigent care trust fund for the state fiscal year beginning July 1, 1998; minus

(ii) an amount equal to the amount deposited into the Medicaid indigent care trust fund under IC 12-15-15-9(d) for the state fiscal years beginning July 1, 2001, and July 1,

2002;

shall be used to fund the state's share of disproportionate share payments to providers under IC 12-15-19-2.1. The remainder of the intergovernmental transfers, if any, must be used to fund the state's share of additional Medicaid payments to hospitals licensed under IC 16-21 pursuant to a methodology adopted by the office.

(D) ~~Of~~ The intergovernmental transfers, which shall include amounts transferred under ~~IC 12-16-7.5-4.5(b), STEP FOUR,~~ **IC 12-16-7.5-4.5,** deposited into the Medicaid indigent care trust fund **and the certifications of public expenditures deemed to be made to the medicaid indigent care trust fund,** for **the** state fiscal years ending after June 30, ~~2003,~~ **2005, but before July 1, 2007,** ~~an amount equal to:~~

~~(i) one hundred percent (100%) of the total intergovernmental transfers deposited into the Medicaid indigent care trust fund for the state fiscal year beginning July 1, 1998, and ending June 30, 1999, minus~~

~~(ii) an amount equal to the amount deposited into the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) for the state fiscal year ending after June 30, 2003,~~

shall be used, ~~to fund the non-federal share of disproportionate share payments to providers under IC 12-15-19-2.1. The remainder of the intergovernmental transfers, if any, for the state fiscal years shall be used to fund, in descending order of priority, the non-federal share of payments to hospitals under IC 12-15-15-9, the non-federal share of payments to hospitals under IC 12-15-15-9.5, the amount to be transferred under clause (F), and the non-federal share of payments under clauses (A) and (B) of STEP FIVE of IC 12-15-15-1.5(b).~~ **in descending order of priority, as follows:**

(i) As provided in clause (B) of STEP THREE of IC 12-16-7.5-4.5(b)(1) and clause (B) of STEP THREE of IC 12-16-7.5-4.5(b)(2), to fund the amount to be transferred to the office.

(ii) As provided in clause (C) of STEP THREE of IC 12-16-7.5-4.5(b)(1) and clause (C) of STEP THREE of IC 12-16-7.5-4.5(b)(2), to fund the non-federal share of the payments made under IC 12-15-15-9 and IC 12-15-15-9.5.

(iii) To fund the non-federal share of the payments made

under IC 12-15-15-1.1, IC 12-15-15-1.3, and IC 12-15-19-8.

(iv) As provided under clause (A) of STEP THREE of IC 12-16-7.5-4.5(b)(1) and clause (A) of STEP THREE of IC 12-16-7.5-4.5(b)(2), for the payment to be made under clause (A) of STEP FIVE of IC 12-15-15-1.5(b).

(v) As provided under STEP FOUR of IC 12-16-7.5-4.5(b)(1) and STEP FOUR of IC 12-16-7.5-4.5(b)(2), to fund the payments to be made under clause (B) of STEP FIVE of IC 12-15-15-1.5(b).

(vi) To fund, in an order of priority determined by the office to best use the available non-federal share, the programs listed in clause (H).

(E) **For state fiscal years ending after June 30, 2007,** the total amount of intergovernmental transfers used to fund the non-federal share of payments to hospitals under IC 12-15-15-9 and IC 12-15-15-9.5 shall not exceed the amount ~~calculated under STEP TWO of the following formula: STEP ONE: Calculate the total amount of funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b).~~

~~STEP TWO: Multiply the state Medicaid medical assistance percentage for the state fiscal year for which the payments under IC 12-15-15-9 and IC 12-15-15-9.5 are to be made by the amount calculated under STEP ONE.~~ **provided in clause (G)(ii).**

(F) As provided in clause (D), for **the following:**

(i) Each **state** fiscal year ending after June 30, 2003, **but before July 1, 2005,** an amount equal to the amount calculated under STEP THREE of the following formula shall be transferred to the office:

STEP ONE: Calculate the product of thirty-five million dollars ($35,000,000) multiplied by the federal medical assistance percentage for federal fiscal year 2003.

STEP TWO: Calculate the sum of the amounts, if any, reasonably estimated by the office to be transferred or otherwise made available to the office for the state fiscal year, and the amounts, if any, actually transferred or otherwise made available to the office for the state fiscal year, under arrangements whereby the office and a hospital licensed under IC 16-21-2 agree that an amount transferred or otherwise made available to the office by the hospital or on behalf of the

hospital shall be included in the calculation under this STEP. STEP THREE: Calculate the amount by which the product calculated under STEP ONE exceeds the sum calculated under STEP TWO.

(ii) The state fiscal years ending after June 30, 2005, but before July 1, 2007, an amount equal to thirty million dollars ($30,000,000) shall be transferred to the office.

(G) Subject to IC 12-15-20.7-2(b), for each state fiscal year ending after June 30, 2007, the total amount in the Medicaid indigent care trust fund, including the amount of intergovernmental transfers of funds transferred, and the amounts of certifications of expenditures eligible for federal financial participation deemed to be transferred, to the Medicaid indigent care trust fund, shall be used to fund the following:

(i) Thirty million dollars ($30,000,000) transferred to the office for the Medicaid budget.

(ii) An amount not to exceed the non-federal share of payments to hospitals under IC 12-15-15-9 and IC 12-15-15-9.5.

(iii) An amount not to exceed the non-federal share of payments to hospitals made under IC 12-15-15-1.1 and IC 12-15-15-1.3.

(iv) An amount not to exceed the non-federal share of disproportionate share payments to hospitals under IC 12-15-19-8.

(v) An amount not to exceed the non-federal share of payments to hospitals under clause (A) of STEP FIVE of IC 12-15-15-1.5(c).

(vi) An amount not to exceed the non-federal share of Medicaid safety-net payments.

(vii) An amount not to exceed the non-federal share of payments to hospitals made under clauses (C) or (D) of STEP FIVE of IC 12-15-15-1.5(c).

(viii) An amount not to exceed the non-federal share of payments to hospitals made under clause (F) of STEP FIVE of IC 12-15-15-1.5(c).

(ix) An amount not to exceed the non-federal share of disproportionate share payments to hospitals under IC 12-15-19-2.1.

(x) If additional funds are available after making payments under items (i) through (ix), to fund other

Medicaid supplemental payments for hospitals approved by the office and included in the Medicaid state plan.

(H) For purposes of clause (D)(vi), the office shall fund the following:

(i) An amount equal to the non-federal share of the payments to the hospital that is eligible under this item, for payments made under clause (C) of STEP FIVE of IC 12-15-15-1.5(b) under an agreement with the office, Medicaid safety-net payments and any payment made under IC 12-15-19-2.1. The amount of the payments to the hospital under this item shall be equal to one hundred percent (100%) of the hospital's hospital-specific limit for state fiscal year 2005, when the payments are combined with payments made under IC 12-15-15-9, IC 12-15-15-9.5, and clause (B) of STEP FIVE of IC 12-15-15-1.5(b) for a state fiscal year. A hospital is eligible under this item if the hospital was eligible for Medicaid disproportionate share hospital payments for the state fiscal year ending June 30, 1998, the hospital received a Medicaid disproportionate share payment under IC 12-15-19-2.1 for state fiscal years 2001, 2002, 2003, and 2004, and the hospital merged two (2) hospitals under a single Medicaid provider number, effective January 1, 2004.

(ii) An amount equal to the non-federal share of payments to hospitals that are eligible under this item, for payments made under clause (C) of STEP FIVE of IC 12-15-15-1.5(b) under an agreement with the office, Medicaid safety-net payments, and any payment made under IC 12-15-19-2.1. The amount of payments to each hospital under this item shall be equal to one hundred percent (100%) of the hospital's hospital-specific limit for state fiscal year 2004, when the payments are combined with payments made to the hospital under IC 12-15-15-9, IC 12-15-15-9.5, and clause (B) of STEP FIVE of IC 12-15-15-1.5(b) for a state fiscal year. A hospital is eligible under this item if the hospital did not receive a payment under item (i), the hospital has less than sixty thousand (60,000) Medicaid inpatient days annually, the hospital either was eligible for Medicaid disproportionate share hospital payments for the state fiscal year ending June 30, 1998 or the hospital met the

office's Medicaid disproportionate share payment criteria based on state fiscal year 1998 data and received a Medicaid disproportionate share payment for the state fiscal year ending June 30, 2001, and the hospital received a Medicaid disproportionate share payment under IC 12-15-19-2.1 for state fiscal years 2001, 2002, 2003, and 2004.

(iii) Subject to IC 12-15-19-6, an amount not less than the non-federal share of Medicaid safety-net payments in accordance with the Medicaid state plan.

(iv) An amount not less than the non-federal share of payments made under clause (C) of STEP FIVE of IC 12-15-15-1.5(b) under an agreement with the office to a hospital having sixty thousand (60,000) Medicaid inpatient days annually.

(v) An amount not less than the non-federal share of Medicaid disproportionate share payments for hospitals eligible under this item, and made under IC 12-15-19-6 and the approved Medicaid state plan. A hospital is eligible for a payment under this item if the hospital is eligible for payments under IC 12-15-19-2.1.

(vi) If additional funds remain after the payments made under (i) through (v), payments approved by the office and under the Medicaid state plan, to fund the non-federal share of other Medicaid supplemental payments for hospitals.

SECTION 11. IC 12-15-20.7-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 2. **(a)** For each state fiscal year **ending before July 1, 2005, and** subject to section 3 of this chapter, the office shall make the payments identified in this section in the following order:

(1) First, payments under IC 12-15-15-9 and IC 12-15-15-9.5.

(2) Second, payments under clauses (A) and (B) of STEP FIVE of IC 12-15-15-1.5(b).

(3) Third, Medicaid inpatient payments for safety-net hospitals and Medicaid outpatient payments for safety-net hospitals.

(4) Fourth, payments under IC 12-15-15-1.1 and 12-15-15-1.3.

(5) Fifth, payments under IC 12-15-19-8 for municipal disproportionate share hospitals.

(6) Sixth, payments under IC 12-15-19-2.1 for disproportionate share hospitals.

(7) Seventh, payments under clause (C) of STEP FIVE of

IC 12-15-15-1.5(b).

(b) For each state fiscal year ending after June 30, 2007, the office shall make the payments for the programs identified in IC 12-15-20-2(8)(G) in the order of priority that best utilizes available non-federal share, Medicaid supplemental payments, and Medicaid disproportionate share payments, and may change the order or priority at any time as necessary for the proper administration of one (1) or more of the payment programs listed in IC 12-15-20-2(8)(G).

SECTION 12. IC 12-16-3.5-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 4. A ~~hospital shall~~ **provider may** provide a patient, and if the patient is not able to understand the statement, the patient's representative, with a statement of the eligibility and benefit standards adopted by the division if at least one (1) of the following occurs:

(1) The ~~hospital~~ **provider** has reason to believe that the patient may be indigent.

(2) The patient requests a statement of the standards.

SECTION 13. IC 12-16-4.5-1, AS AMENDED BY P.L.145-2005, SECTION 8, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1. (a) To receive assistance under the hospital care for the indigent program under this article, a ~~hospital, a physician, a transportation~~ provider, the person, or the person's representative must file an application regarding the person with the division.

(b) Upon receipt of an application under subsection (a), the division shall determine whether the person is a resident of Indiana and, if so, the person's county of residence. If the person is a resident of Indiana, the division shall provide a copy of the application to the county office of the person's county of residence. If the person is not a resident of Indiana, the division shall provide a copy of the application to the county office of the county where the onset of the medical condition that necessitated the care occurred. If the division cannot determine whether the person is a resident of Indiana or, if the person is a resident of Indiana, the person's county of residence, the division shall provide a copy of the application to the county office of the county where the onset of the medical condition that necessitated the care occurred.

(c) A county office that receives a request from the division shall cooperate with the division in determining whether a person is a resident of Indiana and, if the person is a resident of Indiana, the person's county of residence.

SECTION 14. IC 12-16-4.5-2, AS AMENDED BY P.L.145-2005, SECTION 9, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE

JULY 1, 2007]: Sec. 2. A ~~hospital, physician, or transportation~~ provider must file the application with the division not more than forty-five (45) days after the person has been released or discharged from the hospital, unless the person is medically unable and the next of kin or legal representative is unavailable.

SECTION 15. IC 12-16-4.5-7 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 7. (a) A patient must sign an application if the patient is medically able to sign.

(b) If a patient is medically unable to sign an application, the patient's next of kin or a legal representative, if available, may sign the application.

(c) If no person under subsections (a) and (b) is able to sign the application to file a timely application, a ~~hospital~~ **provider's** representative may sign the application instead of the patient.

SECTION 16. IC 12-16-4.5-8.5, AS ADDED BY P.L.145-2005, SECTION 12, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 8.5. A claim for ~~hospital items or services, physician services, or transportation~~ services must be filed with the division not more than one hundred eighty (180) days after the person who received the care has been released or discharged from the hospital. For good cause as determined by the division, this one hundred eighty (180) day limit may be extended or waived for a claim.

SECTION 17. IC 12-16-5.5-1, AS AMENDED BY P.L.145-2005, SECTION 13, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1. (a) The division shall, upon receipt of an application of or for a person who was admitted to, or who was otherwise provided care by a ~~hospital,~~ **provider,** promptly investigate to determine the person's eligibility under the hospital care for the indigent program. The division shall consider the following information obtained by the ~~hospital~~ **provider** regarding the person:

(1) Income.
(2) Resources.
(3) Place of residence.
(4) Medical condition.
~~(5) Hospital care.~~
~~(6)~~ **(5)** Physician care.
~~(7)~~ **(6)** Transportation to and from the hospital.

The division may rely on the ~~hospital's~~ **provider's** information in determining the person's eligibility under the program.

(b) The division may choose not to interview the person if, based on the information provided to the division, the division determines that it appears that the person is eligible for the program. If the division

determines that an interview of the person is necessary, the division shall allow the interview to occur by telephone with the person or with the person's representative if the person is not able to participate in the interview.

(c) The county office located in:

(1) the county where the person is a resident; or

(2) the county where the onset of the medical condition that necessitated the care occurred if the person's Indiana residency or Indiana county of residence cannot be determined;

shall cooperate with the division in determining the person's eligibility under the program.

SECTION 18. IC 12-16-5.5-1.2, AS ADDED BY P.L.145-2005, SECTION 14, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1.2. (a) The division shall, upon receipt of a claim pertaining to a person:

(1) who was ~~admitted to, or who was otherwise~~ provided care by ~~a hospital,~~ **an eligible provider;** and

(2) whose medical condition satisfies one (1) or more of the medical conditions identified in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through IC 12-16-3.5-2(a)(3);

promptly review the claim to determine if the health care items or services identified in the claim were necessitated by the person's medical condition or, if applicable, if the items or services were a direct consequence of the person's medical condition.

(b) In conducting the review of a claim referenced in subsection (a), the division shall calculate the amount of the claim. For purposes of this section, IC 12-15-15-9, IC 12-15-15-9.5, IC 12-16-6.5, and IC 12-16-7.5, the amount of a claim shall be calculated in a manner described in IC 12-16-7.5-2.5(c).

SECTION 19. IC 12-16-5.5-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 2. (a) The ~~hospital providing~~ **provider of** medical care to a patient shall provide information the ~~hospital~~ **provider** has that would assist in the verification of indigency of a patient.

(b) A ~~hospital~~ **provider** that provides information under subsection (a) is immune from civil and criminal liability for divulging the information.

SECTION 20. IC 12-16-5.5-3, AS AMENDED BY P.L.145-2005, SECTION 15, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 3. (a) Subject to subsection (b) and IC 12-16-6.5-1.5, if the division is unable after prompt and diligent

efforts to verify information contained in the application that is reasonably necessary to determine eligibility, the division may deny assistance under the hospital care for the indigent program. The pending expiration of the period specified in IC 12-16-6.5-1.5 is not a valid reason for denying a person's eligibility for the hospital care for the indigent program.

(b) Before denying assistance under the hospital care for the indigent program, the division must provide the person **and** the ~~hospital, and any other~~ provider who submitted a claim under IC 12-16-4.5-8.5 written notice of:

(1) the specific information or verification needed to determine eligibility;

(2) the specific efforts undertaken to obtain the information or verification; and

(3) the statute or rule requiring the information or verification identified under subdivision (1).

(c) The division must provide the ~~hospital and any other~~ provider who submitted a claim under IC 12-16-4.5-8.5 a period of time, not less than ten (10) days beyond the deadline established under IC 12-16-6.5-1.5, to submit to the division information concerning the person's eligibility. If the division does not make a determination of the person's eligibility within ten (10) days after receiving the information under this subsection, the person is eligible without the division's determination of the person's eligibility for the hospital care for the indigent care program under this article.

SECTION 21. IC 12-16-5.5-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 4. The division shall notify in writing the person and the ~~hospital~~ **provider** of the following:

(1) A decision concerning eligibility.

(2) The reasons for a denial of eligibility.

(3) That either party has the right to appeal the decision.

SECTION 22. IC 12-16-6.5-1, AS AMENDED BY P.L.145-2005, SECTION 17, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1. If the division determines that a person is not eligible for assistance for ~~medical care, hospital care, or transportation~~ services, an affected person ~~physician, hospital~~, or ~~transportation~~ provider may appeal to the division not later than ninety (90) days after the mailing of notice of that determination to the affected person ~~physician, hospital,~~ or ~~transportation~~ provider to the last known address of the person ~~physician, hospital,~~ or ~~transportation~~ provider.

SECTION 23. IC 12-16-6.5-1.2, AS ADDED BY P.L.145-2005, SECTION 18, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE

JULY 1, 2007]: Sec. 1.2. (a) If the division determines that an item or service identified in a claim:

(1) was not necessitated by one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through IC 12-16-3.5-2(a)(3); or

(2) was not a direct consequence of one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3);

the affected person ~~physician, hospital, and transportation~~ **or** provider may appeal to the division not later than ninety (90) days after the mailing of the notice of that determination to the affected person ~~physician, hospital,~~ or ~~transportation~~ provider to the last known address of the person ~~physician, hospital,~~ or ~~transportation~~ provider.

(b) If the division determines that an item or service identified in a claim:

(1) was necessitated by one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through IC 12-16-3.5-2(a)(3); or

(2) was a direct consequence of one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3);

but the affected ~~physician, hospital, or transportation~~ provider disagrees with the amount of the claim calculated by the division under IC 12-16-5.5-1.2(b), the affected ~~physician, hospital, or transportation~~ provider may appeal the calculation to the division not later than ninety (90) days after the mailing of the notice of that calculation to the affected ~~physician, hospital, or transportation~~ provider to the last known address of the ~~physician, hospital, or transportation~~ provider.

SECTION 24. IC 12-16-6.5-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 4. A notice of the hearing shall be served upon all persons interested in the matter, including any affected ~~physician, hospital, or transportation~~ provider, at least twenty (20) days before the time fixed for the hearing.

SECTION 25. IC 12-16-7.5-1.2, AS ADDED BY P.L.145-2005, SECTION 23, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1.2. (a) A person determined to be eligible under the hospital care for the indigent program is not financially obligated for ~~hospital items or services, physician services, or transportation~~ services provided to the person during the person's eligibility under the program, if the items or services were:

(1) identified in a claim filed with the division under

IC 12-16-4.5; and

(2) determined:

(A) to have been necessitated by one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through IC 12-16-3.5-2(a)(3); or

(B) to be a direct consequence of one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3).

(b) ~~Based on a hospital's items or services identified in a claim under subsection (a), the hospital~~ **Hospitals** may receive a payment from the office calculated and made under IC 12-15-15-9 and, if applicable, IC 12-15-15-9.5. **Hospitals shall not file claims for payments under IC 12-15-15-9 and IC 12-15-15-9.5 for payments attributable to state fiscal years beginning after June 30, 2007.**

(c) Based on a physician's services identified in a claim under subsection (a), the physician may receive a payment from the division calculated and made under section 5 of this chapter.

(d) Based on the transportation services identified in a claim under subsection (a), the transportation provider may receive a payment from the division calculated and made under section 5 of this chapter.

SECTION 26. IC 12-16-7.5-2.5, AS AMENDED BY P.L.1-2006, SECTION 189, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 2.5. (a) Payable claims shall be segregated by state fiscal year.

(b) For purposes of this chapter, IC 12-15-15-9, IC 12-15-15-9.5, and IC 12-16-14, "payable claim" refers to the following:

(1) Subject to subdivision (2), a claim for payment for physician care, hospital care, or transportation services under this chapter:

(A) that includes, on forms prescribed by the division, all the information required for timely payment;

(B) that is for a period during which the person is determined to be financially and medically eligible for the hospital care for the indigent program; and

(C) for which the payment amounts for the care and services are determined by the division.

This subdivision applies for the state fiscal year ending June 30, 2004.

(2) For state fiscal years ending after June 30, 2004, **and before July 1, 2007,** a claim for payment for physician care, hospital care, or transportation services under this chapter:

(A) provided to a person under the hospital care for the

indigent program under this article during the person's eligibility under the program;

(B) identified in a claim filed with the division; and

(C) determined to:

(i) have been necessitated by one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through IC 12-16-3.5-2(a)(3); or

(ii) be a direct consequence of one (1) or more of the medical conditions listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3).

(3) For state fiscal years beginning after June 30, 2007, a claim for payment for physician care or transportation services under this chapter:

(A) provided to a person under the hospital care for the indigent program under this article during the person's eligibility under the program;

(B) identified in a claim filed with the division; and

(C) determined to:

(i) be necessary after the onset of a medical condition that was manifested by symptoms of sufficient severity that the absence of immediate medical attention would probably result in any of the outcomes described in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3) or IC 12-16-3.5-2(a)(1) through IC 12-16-3.5-2(a)(3); or

(ii) be a direct consequence of the onset of a medical condition that was manifested by symptoms of sufficient severity that the absence of immediate medical attention would probably result in any of the outcomes listed in IC 12-16-3.5-1(a)(1) through IC 12-16-3.5-1(a)(3).

(c) For purposes of this chapter, IC 12-15-15-9, IC 12-15-15-9.5, and IC 12-16-14, "amount" when used in regard to a claim or payable claim means an amount calculated under STEP THREE of the following formula:

STEP ONE: Identify the items and services identified in a claim or payable claim.

STEP TWO: Using the applicable Medicaid fee for service reimbursement rates, calculate the reimbursement amounts for each of the items and services identified in STEP ONE.

STEP THREE: Calculate the sum of the amounts identified in STEP TWO.

(d) For purposes of this chapter, IC 12-15-15-9, IC 12-15-15-9.5,

and IC 12-16-14, a ~~physician, hospital, or transportation~~ provider that submits a claim to the division is considered to have submitted the claim during the state fiscal year during which the amount of the claim was determined under IC 12-16-5.5-1.2(b) or, if successfully appealed by a ~~physician, hospital, or transportation~~ provider, the state fiscal year in which the appeal was decided.

(e) The division shall determine the amount of a claim under IC 12-16-5.5-1.2(b).

SECTION 27. IC 12-16-7.5-4.5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 4.5. (a) Not later than October 31 following the end of each state fiscal year, the division shall:

(1) calculate for each county the total amount of payable claims submitted to the division during the state fiscal year attributed to:

(A) patients who were residents of the county; and

(B) patients:

(i) who were not residents of Indiana;

(ii) whose state of residence could not be determined by the division; and

(iii) who were residents of Indiana but whose county of residence in Indiana could not be determined by the division;

and whose medical condition that necessitated the care or service occurred in the county;

(2) notify each county of the amount of payable claims attributed to the county under the calculation made under subdivision (1); and

(3) with respect to payable claims attributed to a county under subdivision (1):

(A) calculate the total amount of payable claims submitted during the state fiscal year for:

(i) each hospital;

(ii) each physician; and

(iii) each transportation provider; and

(B) determine the amount of each payable claim for each hospital, physician, and transportation provider listed in clause (A).

(b) **For the state fiscal years beginning after June 30, 2005, but before July 1, 2007, and** before November 1 following the end of a state fiscal year, the division shall allocate the funds transferred from a county's hospital care for the indigent fund to the state hospital care for the indigent fund under IC 12-16-14 during or for the **following**

state fiscal ~~year.~~ **years:**

(1) For the state fiscal year ending June 30, 2006, as required under the following STEPS:

STEP ONE: Determine the total amount of funds transferred from all counties' hospital care for the indigent funds by the counties to the state hospital care for the indigent fund under IC 12-16-14 during or for the state fiscal year.

STEP TWO: Of the total amount of payable claims submitted to the division during the state fiscal year from all counties under subsection (a), determine the amount that is the lesser of:

(A) the amount of total physician payable claims and total transportation provider payable claims; or

(B) three million dollars ($3,000,000).

The amount determined under this STEP shall be used by the division to make payments under section 5 of this chapter.

STEP THREE: Transfer an amount equal to the sum of:

(A) the non-federal share of the payments made under clause (A) of STEP FIVE of IC 12-15-15-1.5(b);

(B) the amount transferred under IC 12-15-20-2(8)(F); and

(C) the non-federal share of the payments made under IC 12-15-15-9 and IC 12-15-15-9.5;

to the Medicaid indigent care trust fund for funding the transfer to the office and the non-federal share of the payments identified in this STEP.

STEP FOUR: Transfer an amount equal to sixty-one million dollars ($61,000,000) less the sum of:

(A) the amount determined in STEP TWO; and

(B) the amount transferred under STEP THREE;

to the Medicaid indigent care trust fund for funding the non-federal share of payments under clause (B) of STEP FIVE of IC 12-15-15-1.5(b).

STEP FIVE: Transfer to the Medicaid indigent care trust fund for the programs referenced at IC 12-15-20-2(8)(D)(vi) and funded in accordance with IC 12-15-20-2(8)(H) the amount determined under STEP ONE, less the sum of the amount:

(A) determined in STEP TWO;

(B) transferred in STEP THREE; and

(C) transferred in STEP FOUR.

(2) For the state fiscal year ending June 30, 2007, as required under the following steps:

STEP ONE: Determine the total amount of funds transferred from all counties' hospital care for the indigent funds by the counties to the state hospital care for the indigent fund under IC 12-16-14 during or for the state fiscal year.

STEP TWO: Of the total amount of payable claims submitted to the division during the state fiscal year from all counties under subsection (a), determine the amount that is the lesser of:

(A) the amount of total physician payable claims and total transportation provider payable claims; or

(B) three million dollars ($3,000,000).

The amount determined under this STEP shall be used by the division for making payments under section 5 of this chapter or for the non-federal share of Medicaid payments for physicians and transportation providers, as determined by the office.

STEP THREE: Transfer an amount equal to the sum of:

(A) the non-federal share of five million dollars ($5,000,000) for the payment made under clause (A) of STEP FIVE of IC 12-15-15-1.5(b);

(B) the amount transferred under IC 12-15-20-2(8)(F); and

(C) the non-federal share of the payments made under IC 12-15-15-9 and IC 12-15-15-9.5;

to the Medicaid indigent care trust fund for funding the transfer to the office and the non-federal share of the payments identified in this STEP.

STEP FOUR: Transfer an amount equal to the amount determined under STEP ONE less the sum of:

(A) the amount determined in STEP TWO; and

(B) the amount transferred under STEP THREE;

to the Medicaid indigent care trust fund for funding the non-federal share of payments under clause (B) of STEP FIVE of IC 12-15-15-1.5(b).

(c) For the state fiscal years beginning after June 30, 2007, before November 1 following the end of the state fiscal year, the division shall allocate the funds transferred from a county's hospital care for the indigent fund to the state hospital care for the

indigent fund under IC 12-16-14 during or for the state fiscal year as required under the following STEPS:

STEP ONE: Determine the total amount of funds transferred from a county's hospital care for the indigent fund by the county to the state hospital care for the indigent fund under IC 12-16-14 during or for the state fiscal year.

STEP TWO: Of the total amount of payable claims submitted to the division during the state fiscal year attributed to the county under subsection (a), determine the amount of total ~~hospital payable claims,~~ ~~total~~ physician payable claims, and total transportation provider payable claims. Of the amounts determined for physicians and transportation providers, calculate the sum of those amounts as a percentage of an amount equal to the sum of the total payable physician claims and total payable transportation provider claims attributed to all the counties submitted to the division during the state fiscal year.

STEP THREE: Multiply three million dollars ($3,000,000) by the percentage calculated under STEP TWO.

STEP FOUR: Transfer to the Medicaid indigent care trust fund for purposes of ~~IC 12-15-20-2(8)(D)~~ **IC 12-15-20-2(8)(G)** an amount equal to the amount calculated under STEP ONE, minus an amount equal to the amount calculated under STEP THREE.

STEP FIVE: The division shall retain an amount equal to the amount remaining in the state hospital care for the indigent fund after the transfer in STEP FOUR for purposes of making payments under section 5 of this chapter **or for the non-federal share of Medicaid payments for physicians and transportation providers, as determined by the office.**

~~(c)~~ **(d)** The costs of administering the hospital care for the indigent program, including the processing of claims, shall be paid from the funds transferred to the state hospital care for the indigent fund.

SECTION 28. IC 12-16-7.5-5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 5. Before December 15 following the end of each state fiscal year, the division shall, from the amounts combined from the counties' hospital care for the indigent funds and retained under section 4.5(b) ~~STEP FIVE~~ **or 4.5(c)** of this chapter, pay each physician and transportation provider a pro rata part of that amount. The total payments available under this section may not exceed three million dollars ($3,000,000).

SECTION 29. IC 12-16-14-3, AS AMENDED BY P.L.246-2005, SECTION 111, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 3. (a) ~~For purposes of this section,~~

~~"payable claim" has the meaning set forth in IC 12-16-7.5-2.5(b)(1).~~

~~(b)~~ For taxes first due and payable in 2003, each county shall impose a hospital care for the indigent property tax levy equal to the product of:

(1) the county's hospital care for the indigent property tax levy for taxes first due and payable in 2002; multiplied by

(2) the county's assessed value growth quotient determined under IC 6-1.1-18.5-2 for taxes first due and payable in 2003.

~~(c)~~ **(b)** For taxes first due and payable in 2004, ~~2005, 2006, 2007, and 2008,~~ **and each year after 2004,** each county shall impose a hospital care for the indigent property tax levy equal to the ~~product of:~~ **hospital care for the indigent program property tax levy for taxes first due and payable in the preceding calendar year, multiplied by the statewide average assessed value growth quotients determined under IC 6-1.1-18.5-2, for the year in which the tax levy under this subsection is first due and payable.**

~~(1) the county's hospital care for the indigent property tax levy for taxes first due and payable in the preceding year; multiplied by~~

~~(2) the assessed value growth quotient determined in the last STEP of the following STEPS:~~

~~STEP ONE: Determine the three (3) calendar years that most immediately precede the ensuing calendar year and in which a statewide general reassessment of real property does not first become effective.~~

~~STEP TWO: Compute separately, for each of the calendar years determined in STEP ONE, the quotient (rounded to the nearest ten-thousandth) of the county's total assessed value of all taxable property in the particular calendar year, divided by the county's total assessed value of all taxable property in the calendar year immediately preceding the particular calendar year.~~

~~STEP THREE: Divide the sum of the three (3) quotients computed in STEP TWO by three (3).~~

~~(d) Except as provided in subsection (e):~~

~~(1) for taxes first due and payable in 2009, each county shall impose a hospital care for the indigent property tax levy equal to the average of the annual amount of payable claims attributed to the county under IC 12-16-7.5-4.5 during the state fiscal years beginning:~~

~~(A) July 1, 2005;~~

~~(B) July 1, 2006; and~~

~~(C) July 1, 2007; and~~

~~(2) for all subsequent annual levies under this section, the average~~

~~annual amount of payable claims attributed to the county under IC 12-16-7.5-4.5 during the three (3) most recently completed state fiscal years.~~

~~(c) A county may not impose an annual levy under subsection (d) in an amount greater than the product of:~~

~~(1) The greater of:~~

~~(A) the county's hospital care for the indigent property tax levy for taxes first due and payable in 2008; or~~

~~(B) the amount of the county's maximum hospital care for the indigent property tax levy determined under this subsection for taxes first due and payable in the immediately preceding year; multiplied by~~

~~(2) the assessed value growth quotient determined in the last STEP of the following STEPS:~~

~~STEP ONE: Determine the three (3) calendar years that most immediately precede the ensuing calendar year and in which a statewide general reassessment of real property does not first become effective:~~

~~STEP TWO: Compute separately, for each of the calendar years determined in STEP ONE, the quotient (rounded to the nearest ten-thousandth) of the county's total assessed value of all taxable property in the particular calendar year, divided by the county's total assessed value of all taxable property in the calendar year immediately preceding the particular calendar year.~~

~~STEP THREE: Divide the sum of the three (3) quotients computed in STEP TWO by three (3).~~

SECTION 30. IC 34-30-2-45.7 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 45.7. IC 12-16-5.5-2 (Concerning ~~hospitals~~ **providers** for providing information verifying indigency of patient).

SECTION 31. THE FOLLOWING ARE REPEALED [EFFECTIVE JULY 1, 2007]: IC 12-15-15-9.8; IC 12-15-20.7-3; IC 12-16-2.5-6.5; IC 12-16-8.5; IC 12-16-12.5.

SECTION 32. [EFFECTIVE UPON PASSAGE] **(a) As used in this SECTION, "office" refers to the office of Medicaid policy and planning established by IC 12-8-6-1.**

(b) The office shall apply to the United States Department of Health and Human Services for approval of an amendment to the state's Medicaid plan that is necessary to do the following:

(1) Amend the state's upper payment limit program.

(2) Make changes to the state's disproportionate share hospital program.

(c) The office may not implement an approved amendment to the state plan until the office files an affidavit with the governor attesting that the state plan amendment applied for under subsection (b)(1) or (b)(2) of this SECTION is in effect. The office shall file the affidavit under this subsection not later than five (5) days after the office is notified that the state plan amendment is approved.

(d) The office may adopt rules under IC 4-22-2 necessary to implement this SECTION.

(e) This SECTION expires December 31, 2013.

SECTION 33. [EFFECTIVE UPON PASSAGE] **(a) Not later than November 1, 2008, the department of insurance and the office of the secretary of family and social services shall study and make a final recommendation to the legislative council, in an electronic format under IC 5-14-6, concerning the following:**

(1) A plan to provide health insurance coverage to individuals who:

(A) have a family income that is more than two hundred percent (200%) of the federal income poverty level; and

(B) are uninsured.

(2) A health insurance program that would require local government employers, school corporations, and other public employers to join together to purchase employee health insurance coverage.

(b) The health finance commission shall study during the 2007 interim of the general assembly:

(1) reimbursement rates to providers under; and

(2) premium costs of;

accident and sickness insurance policies and health maintenance organization contracts.

(c) This SECTION expires December 31, 2008.

SECTION 34. [EFFECTIVE UPON PASSAGE] **(a) As used in this SECTION, "commission" refers to the health finance commission established by IC 2-5-23-3.**

(b) The commission shall, during the 2007 legislative interim, study the following concerning the Indiana tobacco use prevention and cessation program:

(1) The effectiveness of the program.

(2) Whether the program should be transferred to the state department of health.

(c) This SECTION expires December 31, 2007.

SECTION 35. [EFFECTIVE UPON PASSAGE] **(a) Not later than**

November 1, 2008, the office of the secretary of family and social services shall study and make a final recommendation to the legislative council, in an electronic format under IC 5-14-6, concerning the viability of keeping members of a family who are eligible for:

(1) Medicaid;

(2) the children's health insurance program; or

(3) other state health care assistance plans;

together under the same health care plan by using health care accounts, market-based contributions by the recipients, assignment of Medicaid patients to private health insurance, or other health care plans.

(b) This SECTION expires December 31, 2008.

SECTION 36. **An emergency is declared for this act.**

President of the Senate

President Pro Tempore

Speaker of the House of Representatives

Governor of the State of Indiana

Date: _____ Time: _____

C o p y